EXHIBIT

"K"

INMATE APPEAL ASSIGNMENT NOTICE

To: INMATE WOODSON, P76095
Current Housing: D8-124

Date: June 14, 2006

From: INMATE APPEALS OFFICE

Re: APPEAL

ASSIGNED STAFF REVIEWER: CTC
APPEAL ISSUE: MEDICAL

Inmate WOODSON, this acts as a notice to you that your appeal has been sent to the above staff for INFORMAL response. If you have any questions, contact the above staff member. If dissatisfied, you have 15 days from the receipt of the response to forward your appeal to this office for the FIRST level of review.

T. VARIZ, CC-II / E. MEDINA CC-II
Appeals Coordinators
Salinas Valley State Prison

№ 965520

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

A fee of $5.00 may be charged to your trust account for each health care visit.

If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.

REQUEST FOR: MEDICAL ☐ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☑

NAME	CDC NUMBER	HOUSING
Woodson	P-76095	D-8-124

PATIENT SIGNATURE | DATE: 4-13-06

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem) "Follow up" on Ibuprofen. The administration and C-facility has retaliated against me for reporting misconduct and placed me in Ad-Seg. They have thrown away my medication. Please send me a refill. Thank you. Also send me a copy of this request.

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

☐ Visit is not exempt from $5.00 copayment. (Send pink copy to Inmate Trust Office.)

PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received: 0800 4-13-6	Received by: John Anderson
Date / Time Reviewed by RN:	Reviewed by: John Anderson

S: Pain Scale: 1 2 3 4 5 6 7 8 9 10

Med. came Resolved -

40. Skin Eruption - (R) Knee

O: T: P: 73 R: 14 BP: 122/77 WEIGHT: # 215

Hx Scrape abrasion (R) Knee. - now Skin eruption - ? infection denies chills

A: Eruption - Skin (R) Knee or sweats -

P: Medline -

☐ See Nursing Encounter Form

✓ Motrin 600 mg -

E: RTC PRN - Keep appt - Medline -

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐
REFERRED TO PCP:		DATE OF APPOINTMENT:	
COMPLETED BY		NAME OF INSTITUTION: SVSP	

PRINT / STAMP NAME	SIGNATURE / TITLE	DATE/TIME COMPLETED
		4-18-6 . 1430

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STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

Re 950790

PART I: TO BE COMPLETED BY THE PATIENT

A fee of $5.00 may be charged to your trust account for each health care visit.

If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.

REQUEST FOR: MEDICAL ☑ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
Woodson	P-76095	C-3-105

PATIENT SIGNATURE	DATE
Thomas W Woodson	3/25/06

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem) Dr. Sid, Please send me two copies of My 7219 Injury report documented 3-23-06. A.S.A.P - Also need stronger pain Medication. The brutal Assault upon My person has increased My Suffering.

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

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PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received:	Received by:
Date / Time Reviewed by RN: 3/25 @ 11:15	Reviewed by:

S: Inmate insists this RN provide him with copies of 7219 + that staff has done this in the past. Demanding stronger meds. Accused this writer of being part of a cover up.

Pain Scale: 1 2 3 4 5 6 7 8 9 10

O: T: P: R: BP: WEIGHT:

Told inmate at all past that this info could not be provided by C-Med + could be obtained by submitting request for Health records. He then became demanding calling me a liar & part of conspiracy cover up.

A: Wants 7219. Agitated. Requested to see MD for stronger meds

P: OK to evaluate Tues

☐ See Nursing Encounter Form

E:

MD - Inmate request stronger Meds

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☑
REFERRED TO PCP:		DATE OF APPOINTMENT:	
COMPLETED BY: Nina Moore		NAME OF INSTITUTION: SVSP	

PRINT / STAMP NAME	SIGNATURE / TITLE	DATE/TIME COMPLETED
Nina Moore R.N.	Nina Moore R.N.	3-27-06 14:10

NV

RE 946140

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

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If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.

REQUEST FOR: MEDICAL ☑ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
Woodson	P-76095	C-3-105

PATIENT SIGNATURE: Thomas D Woodson DATE: 3/26/06

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem)

Shoulder joint feeling very weak after being seperated due to excessive force on March 23, 2006. May have ligament damage need prescription to help heal ligaments. Do not destroy this slip

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

☐ Visit is not exempt from $5.00 copayment. (Send pink copy to Inmate Trust Office.)

PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received: 3/27/06 0800 Received by:

Date / Time Reviewed by RN: 3/27/06 0800 Reviewed by:

Pain Scale: 1 2 3 4 5 6 7 8 9 10

S: States Rt shoulder is painful & burning; putting pressure on back. When I put pressure on ~~Rt~~ Rt knee it feels like it is going to give out. - Inmate hostile & sarcastic

O: T: 98 P: 48 R: 18 BP: 177/94 WEIGHT: Muscular

On Thurs on 23th Inmate had to be ~~carried~~ carried to hobby because he repeatedly dropped to knee while being escorted to hobby - C/O injury to Rt shoulder back, Rt Knee

A: ~~Inmate~~ reports injury from incident of 3.24 - Rt shoulder, back, Rt Knee

P: Refer to MD for Eval - Inmate forwarding MD appt

☐ **See Nursing Encounter Form**

NO

E:

~~Injury Rt shoulder~~

MD Eval

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐
REFERRED TO PCP:		DATE OF APPOINTMENT:	
COMPLETED BY: Nina Moore		NAME OF INSTITUTION: SVSP	
PRINT / STAMP NAME: Nina M	SIGNATURE / TITLE: Nina Moore		DATE/TIME COMPLETED: 3-28-07 11:45

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STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

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REQUEST FOR: MEDICAL ☑ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
Woodson	P-76085	C-3-105

PATIENT SIGNATURE

DATE: 4/6/06

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem) Follow up I've sent three slips in since I was assaulted and injured by C/O's on 3-23-06. I'm requesting for the fourth time about seeing a doctor about my damage shoulder and stronger pain medication.

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

☐ Visit is not exempt from $5.00 copayment. (Send pink copy to Inmate Trust Office.)

PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received: 4/8/06	**Received by:**
Date / Time Reviewed by RN:	**Reviewed by:**

S: Pain Scale: 1 2 3 4 5 6 7 8 9 10

O: T: P: R: BP: WEIGHT:

A:

P: seen by MD 4/7/06.

☐ **See Nursing Encounter Form**

'NTMENT ULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐
'ED TO PCP:		DATE OF APPOINTMENT:	
ED BY: Ryan RN		NAME OF INSTITUTION: SVSP	
AMP NAME: Ryan RN	SIGNATURE / TITLE	DATE/TIME COMPLETED: 4/8/06	

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

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If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.

REQUEST FOR: MEDICAL ☐ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☑

NAME	CDC NUMBER	HOUSING
Woodson	P-76095	D2 127

PATIENT SIGNATURE: Thomas Woodson DATE:

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem)

Please Refill My Medication for Back Pain, Shoulder Knee and feet Pain! I Take Baclofen/Ibuprofen, have been Since March, 2005. Please Refill

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

☐ Visit is not exempt from $5.00 copayment. (Send pink copy to Inmate Trust Office.)

PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received:	**Received by:** C.Flynn RN
Date / Time Reviewed by RN:	**Reviewed by:** C.Flynn RN

S: Pain Scale: 1 2 3 4 5 6 7 8 9 10

O: T: P: R: BP: WEIGHT:

A:

P: On MD line. Exam M.D. on 8/11/06

☐ **See Nursing Encounter Form**

E:

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐
REFERRED TO PCP:		DATE OF APPOINTMENT:	
COMPLETED BY:	8/11/06	NAME OF INSTITUTION: SVSP	
PRINT / STAMP NAME	SIGNATURE / TITLE	DATE/TIME COMPLETED	

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

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REQUEST FOR: MEDICAL ☐ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☑

NAME	CDC NUMBER	HOUSING
Woodson	P76095	D-2-127

PATIENT SIGNATURE	DATE
Thomas Woodson	6/28/06

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem)

30mg Baclofen / Ibuprofen for Pain.

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

☐ Visit is not exempt from $5.00 copayment. (Send pink copy to Inmate Trust Office.)

PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received: 06-29-06A07:21 RCVD	**Received by:** C.Flynn RN
Date / Time Reviewed by RN: 06-29-06A07:21 RCVD	**Reviewed by:** C.Flynn RN

S: Pain Scale: 1 2 3 4 5 6 7 8 9 10

O: T: P: R: BP: WEIGHT:

A: See Soap Note. — C.Flynn RN

P: MD line for reviewal

☐ **See Nursing Encounter Form**

E:

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐

REFERRED TO PCP:	DATE OF APPOINTMENT:
COMPLETED BY: C Flynn RN	NAME OF INSTITUTION: SVSP

PRINT / STAMP NAME	SIGNATURE / TITLE	DATE/TIME COMPLETED
C Flynn RN	C Flynn	6/29/06

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№ 966643

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

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REQUEST FOR: MEDICAL ☐ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
Woodson	P-76095	D-2-127

PATIENT SIGNATURE	DATE
Thomas Woodson	6-29-06

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem)

C/O's J. Rodriguez, and E. Camarena stole Patients Lumbar Support brace. Need brace replaced. Paved $20.00 for it in February 06. 602 is already in on it. They are not returning it to me.

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

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PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received: 29 JUN 06 @ 12	Received by:
Date / Time Reviewed by RN:	Reviewed by:

S: Pain Scale: 1 2 3 4 5 6 7 8 9 10

O: T: P: R: BP: WEIGHT:

A:

P: I'm informed this is a custody issue. and needs to speak to SRs for yard. SRs

☐ See Nursing Encounter Form

E:

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐
REFERRED TO PCP:		DATE OF APPOINTMENT:	
COMPLETED BY: C.Flynn RN		NAME OF INSTITUTION: SVSP	

PRINT / STAMP NAME	SIGNATURE / TITLE	DATE/TIME COMPLETED
C.Flynn RN		6/30/06

CDC 7362 (Rev. 03/04) Original - Unit Health Record Yellow - Inmate (if copayment applicable) Pink - Inmate Trust Office (if copayment applicable) Gold - Inmate

№ 956995

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

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REQUEST FOR: MEDICAL ☐ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
Woodson	P-76095	D-2-127

PATIENT SIGNATURE: [signature] DATE: 6/30/06

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem)

Follow up on My Back Pain. Have NO Mattress Back is Injured.

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

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PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received:	Received by:
Date / Time Reviewed by RN: 7-6 11a	Reviewed by: M-m RN

S: Pain Scale: 1 2 3 4 5 6 7 8 9 10

O: T: P: R: BP: WEIGHT:

A:

P: Meds Reordered. MD X14 for chrono review

☐ **See Nursing Encounter Form**

E:

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☒
REFERRED TO PCP: MD 7/5/06 chrono.		DATE OF APPOINTMENT:	
COMPLETED BY: C.Flynn RN		NAME OF INSTITUTION: SVSP	
PRINT / STAMP NAME: C.Flynn RN	SIGNATURE / TITLE: [signature]		DATE/TIME COMPLETED: 7/5/06

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№ 968871

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

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REQUEST FOR: MEDICAL ☐ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☑

NAME	CDC NUMBER	HOUSING
Woodson	P-76095	D-2-127

PATIENT SIGNATURE: James Woodson DATE: 7/3/06

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem)

Third Slip I need refill on Pain Medication Please! Baclofen/Ibuprofen

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

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PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received: 3 Jan 06 @ 12	**Received by:**
Date / Time Reviewed by RN: 7-4-06	**Reviewed by:**

S: Pain Scale: 1 2 3 4 5 6 7 8 9 10

O: T: P: R: BP: WEIGHT:

A:

P: see Slip 956995.

☐ **See Nursing Encounter Form**

E:

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐

REFERRED TO PCP:	DATE OF APPOINTMENT:
COMPLETED BY: C.Flynn RN	NAME OF INSTITUTION: SVSP

PRINT / STAMP NAME	SIGNATURE / TITLE	DATE/TIME COMPLETED
C.Flynn RN		7/5/06

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STATE OF CALIFORNIA
CDC 7393 (11/02)

DEPARTMENT OF CORRECTIONS

NOTIFICATION OF DIAGNOSTIC TEST RESULTS

NAME	CDC NUMBER
Woodson	P76095
INSTITUTION: SVSP	HOUSING:
TYPE OF TEST: Ultrasound MRI	DATE OF TEST: 4/14/06

YOUR TEST RESULTS HAVE BEEN EVALUATED BY A PHYSICIAN AND THE FOLLOWING HAS BEEN DETERMINED:

- ☐ Your test results are essentially within normal limits or are unchanged and no physician follow up is required.
- ☒ You are being scheduled for a follow up medical appointment. You will be receiving a ducat indicating your appointment time.
- ☐ A repeat test will be ordered. You will be ducated for this test.
- ☐ A chronic care appointment has been scheduled for you. You will be receiving a ducat indicating your appointment time.

R Heaney FNP
NAME / TITLE

PHYSICIAN SIGNATURE

6/19/06
DATE

ORIGINAL - File in UHR CANARY - Scheduler PINK - Patient